on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. If you request an exception, your physician must provide a statement to support your request.

For more information about coverage determinations and exceptions, see the section "How to request a coverage determination" below.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. **You cannot request an appeal if we have not issued a coverage determination.** If we issue an unfavorable coverage determination, you may file an appeal called a "redetermination" if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights. For more information about appeals, see the section "How to request an appeal" below.

How to request a coverage determination

What is the purpose of this section?

This part of Section 12 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

What is a coverage determination?

The coverage determination made by Seniority Plus is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered you should contact Seniority Plus and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you can "appeal" the decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage determinations:

- You ask us to pay for a prescription drug you have already received. This is a request for a coverage determination about payment. You can call us at **1-800-275-4737** (TTY/TDD **1-800-929-9955**) to get help in making this request.
- You ask for a Part D drug that is not on your plan's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can call us at **1-800-275-4737** (TTY/TDD **1-800-929-9955**) to ask for this type of decision. See "What is an exception" below for more information about the exceptions process.

- You ask for an exception to our plan's utilization management tools - such as dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. You can call us at **1-800-275-4737** (TTY/TDD **1-800-929-9955**) to ask for this type of decision. See "What is an exception" below for more information about the exceptions process.

- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can call us at **1-800-275-4737** (TTY/TDD **1-800-929-9955**) to ask for this type of decision. See "What is an exception" below for more information about the exceptions process.

- You ask us to reimburse you for a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the plan. See page 52 for a description of these circumstances. You can call us at **1-800-275-4737** (TTY/TDD **1-800-929-9955**) to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of Seniority Plus apply to your specific situation. This booklet and any amendments you may receive describe the Part D prescription drug benefits covered by Seniority Plus, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by Seniority Plus).

What is an exception?

An exception is a type of coverage determination. You can ask us to make an exception to our coverage rules in a number of situations.

- You can ask us to cover your drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the co-payment amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Specialty Group A and Specialty Group B Tiers.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan formulary or the drug in the non-preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your physician must submit a statement supporting your exception request. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

If we approve your exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you can appeal our decision.

Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment or co-insurance amount we require you to pay for the drug.

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing physician or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at Health Net Seniority Plus Appeals & Grievances Department, Post Office Box 10450,Van Nuys, CA 91410-0450. You can call us at **1-800-275-4737** (TTY/TDD **1-800-929-9955**) to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a "standard" or "fast" coverage determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?

A decision about whether we will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours; see below), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited coverage determination."

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should call us at **1-800-275-4737** (for TTY, call **1-800-929-9955**). Or, you can deliver a written request to

Health Net Pharmacy Department, Post Office Box 9103, Van Nuys, CA 91403-9103, or fax it to **1-916-463-9754**. Requests received after business hours are handled on the next business day.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling us at **1-800-275-4737** (for TTY, call **1-800-929-9955**). Or, you can deliver a written request to Health Net Pharmacy Department, Post Office Box 9103, Van Nuys, CA 91403-9103, or fax it to **1-916-463-9754**. Be sure to ask for a "fast," "expedited," or "24-hour" review. To request a fast decision outside of regular weekday business hours, call **1-800-275-4737** (TTY/TDD users should call the California Relay Service at **711** or **1-800-735-2929**).

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72 hour standard timeframe.

What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

1. **For a <u>standard</u> coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.**

Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as dosage or quantity limits or step therapy requirements), we must give you our decision no later than 72 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is Medically Necessary. If you are requesting an exception, you should submit your prescribing physician's supporting statement with the request, if possible.

We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If you have not received an answer from us within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

2. For a fast coverage determination about a Part D drug that you have not received.

If you receive a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review – sooner if your health requires. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is Medically Necessary.

We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

If we do not grant your or your physician's request for a fast review, we will give you our decision within the standard 72 hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.

We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we have received your physician's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

2. For a fast decision about a Part D drug that you have not received.

We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we have received your physician's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that

we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1).

How to request an appeal

This part of Section 12 explains what you can do if you disagree with our coverage determination decision.

What kinds of decisions can be appealed?

If you are unhappy with our coverage determination decision, you can ask for an appeal called a "redetermination." You can generally appeal our decision not to cover a Part D drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for, if you think we should have reimbursed you more than you received, or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exceptions request, you can appeal.

How does the appeals process work?

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one level to the next.** At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

- **Who makes the decision at each level?** You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny any part of your request, you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is sent outside of Health Net, where people who are not connected to us review your case and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the federal court system. This will help ensure a fair, impartial decision. Each appeal level is discussed in greater detail below.

Appeal Level 1: If we deny part or all or part of your request in our coverage determination, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination."

Please call us at **1-800-275-4737** (TTY/TDD **1-800-929-9955**) if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we receive your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?" and "Asking for a fast decision."

While the process for deciding on a standard or fast appeal is the same as in the case of a coverage determination, the place where the appeal is sent is different. See "What if you want a 'fast' appeal" later in this section for more information.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Seniority Plus, Appeals and Grievance Department, Post Office Box 10450, Van Nuys, California 91410-0450.
- By fax, at **1-800-977-1959**.
- By telephone – if it is a fast appeal – at **1-800-275-4737** (TTY/TDD **1-800-929-9955**).
- In person, at 21281 Burbank Boulevard, Woodland Hills, California, 91367.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at **1-800-275-4737** (TTY/TDD **1-800-929-9955**), Seniority Plus, Appeals and Grievance Department, Post Office Box 10450, Van Nuys, California 91410-0450.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing physician.

How soon must you file your appeal?

You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the appeal to us in writing at Seniority Plus, Appeals and Grievance Department, Post Office Box 10450, Van Nuys, California 91410-0450.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling us at **1-800-275-4737** (for TTY, call **1-800-929-9955**). Or, you can deliver a written request to Seniority Plus, Appeals and Grievance Department, Post Office Box 10450, Van Nuys, California 91410-0450, or fax it to **1-800-977-1959**. Be sure to ask for a "fast," "expedited," or "72-hour" review. Requests received after business hours are handled on the next business day. To reach us after business hours, please fax us at **1-800-977-1959.**

Remember, that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal. While the process for deciding on a standard or fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent to is the same as the contact information above. See "Getting information to support your appeal."

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. **For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.**

After we receive your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will automatically go to the second level of appeal, where an independent review organization will review your case.

2. For a fast decision about a Part D drug that you have not received.

After we receive your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What happens next if we decide completely in your favor?

1. For a decision about reimbursement for a Part D drug you already paid for and received.

We must send payment to you no later than 30 calendar days after we receive your request to reconsider our coverage determination.

2. For a standard decision about a Part D drug you have not received.

We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we received your appeal.

3. For a fast decision about a Part D drug you have not received.

We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 72 hours after we received your appeal.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent review organization, to review your case. This independent review organization contracts with the federal government and is not part of Health Net.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization.

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the independent review organization whose name and address is included in the redetermination you receive from Health Net.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing physician cannot file the request for you – only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under "Asking for a fast decision." Remember, if your prescribing physician provides a written or oral statement supporting your request for a fast appeal, the independent review organization will automatically treat you as eligible for a fast appeal.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it received your request to give you a decision.
2. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it receives the request to give you a decision.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. ***For a decision about reimbursement for a Part D drug you already paid for and received.***

   We must pay within 30 calendar days from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

2. **For a standard decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

What happens next if the independent review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is $110 or more.

Appeal Level 3: If the independent review organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to the ALJ Field Office indicated in the Notice of Reconsideration letter sent by the independent review organization. The address and contact information for the ALJ Field Office is located in this notice. ALJ Field Office's can also be found at http://www.hhs.gov/omha/offices.html.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than $110. If the dollar value is less than $110, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based what you would be charged for the drug and on the number of refills prescribed for the requested drug during the plan year. Projected value includes your co-payments, all expenditures incurred after your expenditures exceed the initial coverage limit, and expenditures paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor:

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you no later than 30 calendar days from the date we receive notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Judge rules against you:

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to you request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor:

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you no later than 30 calendar days from the date we receive notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Council decides against you:

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than $1,130, the Council's decision is final and you may not take the appeal any further

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeal Council's decision, you may ask a Federal Court Judge to review the case.

How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor:

Once we receive notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you within 30 calendar days from the date we receive notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Judge decides against you:

The Judge's decision is final and you may not take the appeal any further.

Section 13 Leaving Seniority Plus and your choices for continuing Medicare after you leave

What is "Disenrollment"?

"Disenrollment" from Seniority Plus means **ending your membership** in Seniority Plus. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave Seniority Plus because you have decided that you *want* to leave. You can do this for any reason. However, as we explain in this section, **there are limits to when you may leave and how often you can make changes, what your other choices are for receiving Medicare services, and how you can make changes.**
- There are also a few situations where you would be *required* to leave. For example, you would have to leave Seniority Plus if you move permanently out of our geographic Service Area or if Health Net leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership ends, you must keep getting your Medicare services through Seniority Plus or you will have to pay for them yourself

If you leave Seniority Plus, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through Seniority Plus.

If you get services from doctors or other medical providers who are **not** plan providers before your membership in Seniority Plus ends, neither Health Net nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call Member Services at the number in Section 1 to find out if your hospital care will be covered by Seniority Plus. If you have any questions about leaving Seniority Plus, please call us at Member Services.

What should I do if I decide to leave Seniority Plus?

If you want to leave Seniority Plus:

- The first step is to **be sure that the type of change you want to make and when you want to make it fit with the new rules** explained below about changing how you

get Medicare. If the change does not fit with these rules, you won't be allowed to make the change.

- Then, what you must do to leave Seniority Plus depends on whether you want to switch to Original Medicare or to one of your other choices.

When and how often can I change my Medicare choices?

In general, there are only certain times during the year when you can change the way you get Medicare.

Here are the rules:

1. From November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1. During the AEP, you are **not limited** in the type of change you may make to your coverage. See "What are my choices, and how do I make changes, if I leave Seniority Plus between November 15 and December 31?" below for details.
2. From January 1 until March 31, during the Medicare Advantage Open Enrollment Period (OEP), anyone eligible for Medicare Advantage has another chance to review the coverage they have and make one change. Your new enrollment will be effective the first day of the month that comes *after* the month we receive your request to leave. However, with this chance, you **are limited** in the type of plan you may join. ***You may not use this chance to add or drop Medicare prescription drug coverage.*** See "What are my choices, and how do I make changes, if I leave Seniority Plus between January 1 and March 31?" below for details.

Generally, you can't make any other changes during the year unless you meet special exceptions, such as if you move or if you have Medicaid coverage. Contact us for information.

What are my choices, and how do I make changes, if I leave Seniority Plus between November 15 and December 31?

If you leave Seniority Plus between November 15 and December 31 (during the AEP), you have a number of choices for how you receive your Medicare after you leave. If they are available in your area, and if they are accepting new members, you can switch to any of the following types of plans:

- **Other Medicare Advantage Plans** (including HMOs such as Seniority Plus, PPOs, and Private Fee-for-service plans) are available in some parts of the country. In HMOs and PPOs, you generally get all your Medicare-covered Part A and Part B health care through the plan. Medicare Advantage Plans ***may include prescription drug coverage*** as part of the Medicare Prescription Drug (Part D) benefit. Medicare pays a set amount of money for your care every month to these private health plans whether or not you use services. Seniority Plus is a Medicare Advantage Plan offered by Health Net.

- **Original Medicare** is available throughout the country. Original Medicare is a fee-for-service health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
- **Medicare Prescription Drug Plans** (PDPs) are stand-alone drug plans that only cover prescription drugs, not other benefits or services. If you choose Original Medicare and want to receive Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan.
- **Other Medicare Health Plans** (including Medicare Cost Plans, Programs of All-Inclusive Care for the Elderly (PACE), and Demonstrations) may be available. In some of these plans, you generally get all your Medicare-covered health care from that plan. This coverage ***may include prescription drug coverage.***

Note: For more information about your choices, please refer to the "Medicare & You" handbook you received in the fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit **www.medicare.gov** to learn more about your choices.

How do I switch from Seniority Plus to another Medicare Advantage Plan or Other Medicare Health Plan between November 15 and December 31?

If you want to change from Seniority Plus to a different Medicare Advantage Plan or Other Medicare Health Plan, here is what to do:

1. Contact the new plan you want to join to be sure it is accepting new members. Also ask the plan if it offers the Medicare Part D prescription drug benefit.
2. Your new plan will tell you the date when your membership in that plan begins, and your membership in Seniority Plus will end on that same day (this will be your "Disenrollment date"). Remember, you are still a member until your Disenrollment date, and must continue to get your medical care as usual through Seniority Plus until the date your membership ends.

What if I want to switch (disenroll) from Seniority Plus to Original Medicare between November 15 and December 31?

Original Medicare does not cover very many prescription drugs outside of a hospital. So, if you want to change from Seniority Plus to Original Medicare, you should think about whether you want to also join a Medicare Prescription Drug Plan.

To get information about Prescription Drug Plans that you can join, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

- If you want Original Medicare *and* Medicare prescription drug coverage, simply enroll in a stand-alone Medicare Prescription Drug Plan (PDP). That will automatically disenroll you from Seniority Plus.
- If you want Original Medicare and do *not* want Medicare prescription drug coverage, simply tell us or Medicare that you want to leave Seniority Plus. You do *not* have to enroll in Original Medicare, because you will automatically be in Original Medicare when you leave Seniority Plus.
    - **To tell us** that you want to leave Seniority Plus:
        - You can write or fax a letter to us or fill out a Disenrollment form and send it to Member Services at Health Net Enrollment Services, Post Office Box 10420, Van Nuys, California 91410-0198 or to our fax number at **1-818-676-7035**. Be sure to sign and date your letter or form. To get a Disenrollment form, call us at the Member Services telephone number shown in Section 1.
    - **To tell Medicare** you want to leave Seniority Plus, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Whether you tell us or Medicare that you want to leave Seniority Plus you will receive a letter telling you when your membership will end. This is your **Disenrollment date** – the day you officially leave Seniority Plus. Your Disenrollment date will be January 1. Remember, until January 1, you are still a Member of Seniority Plus and must continue to get your medical care as usual through Seniority Plus.

Effective January 1, your membership in Seniority Plus ends and you should use your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave Seniority Plus. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

What are my choices, and how do I make changes, if I leave Seniority Plus between January 1 and March 31?

Between January 1 and March 31 of every year, individuals who are enrolled in (or eligible for) Medicare Advantage Plans have one opportunity to make (1) change to their Medicare Advantage coverage. This period *may not be used to add or drop Medicare prescription drug coverage.* After March 31, you generally cannot change plans or discontinue your membership.

After March 31, you generally cannot change plans or discontinue your membership.

If plans are available in your area, and if they are accepting new members, you can make one of the following changes:

- As a member of a Medicare Advantage Plan *with* prescription drug coverage (MA-PD), between January 1 and March 31, changes you can make include:

A. Switch to another Medicare Advantage Plan with prescription drug coverage (MA-PD) by enrolling in the new MA-PD plan; **or**

B. Switch to Original Medicare and a Prescription Drug Plan (PDP) by enrolling in the PDP.

Do I need to buy a Medigap (Medicare Supplement Insurance) policy?

If you want to change from Seniority Plus to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact HICAP (the phone number is in Section 1). You can ask HICAP about how and when to buy a Medigap policy if you need one. HICAP can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you are at least 65 and have been eligible for Part B for less than six months, you may still be in your Medigap open enrollment period. If you leave our plan while you are still in your open enrollment period, a Medigap insurer cannot refuse to sell you any policy you choose or impose limits based on your health. You might also have a "guaranteed issue right". This means that in certain circumstances, and for a limited period of time, a Medigap insurer must sell you a Medigap policy, even if you have health problems. In general, you do not have a guaranteed issue right if you simply decide to disenroll from Seniority Plus. However, for example, you have a guaranteed issue right to buy a Medigap policy if you are in a trial period. You may be in a trial period if, in the past 12 months you: (1) dropped a Medigap policy to join Seniority Plus or Medicare health plan for the first time; or (2) joined Seniority Plus or another Medicare health plan when you first became entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. You may also have a guaranteed issue right if you move out of our service area. HICAP can tell you about other situations where you may have guaranteed issue rights. If you do want to buy a Medigap policy, you have to follow the instructions below for changing from Seniority Plus to Original Medicare. (Buying a Medigap policy does not switch you from Seniority Plus to Original Medicare. In fact, while you are still enrolled in Seniority Plus, it is against the law for a Medigap insurance company to sell you a policy. A Medigap sales person or insurance agent cannot cancel your Seniority Plus membership and put you in Original Medicare.)

What happens to you if Health Net leaves the Medicare program or Seniority Plus leaves the area where you live?

If we leave the Medicare program or change our Service Area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in Seniority Plus will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through Seniority Plus until your membership ends.

Your choices for how to get your Medicare will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another Health Net plan, another Medicare Advantage Plan, or a Private Fee-for-

Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from Seniority Plus to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a "guaranteed issue right" and it is explained earlier in this section under the heading, "Do you need to buy a Medigap (Medicare Supplement Insurance) policy?"

Health Net has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Health Net or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time during the year, too. In these situations we will try to tell you 90 days in advance, but your advance notice may be as little as 30 or fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops serving your area, you will be provided a special enrollment period to make choices about how you get Medicare, including choosing a Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

Under certain conditions Health Net can end your membership and make you leave the plan

Generally, we *cannot* ask you to leave the plan because of your health

Unless you are a member of a Medicare Advantage Special Needs Plan (SNP) for chronic conditions, we cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave Seniority Plus because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

We *can* ask you to leave the plan under certain special conditions

If any of the following situations occur, we will end your membership in Health Net.

- If you move out of the service area or are away from the service area for more than six months in a row. If you plan to move or take a long trip, please call Member Services at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in Seniority Plus's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row, you generally cannot remain a member of Seniority Plus. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). An earlier part of this section tells about the choices you have if you leave Seniority Plus and explains how to leave. Section 2 gives more information about getting care when you are away from the service area.

- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 8 for information about staying enrolled in Part A and Part B). Please remember if you are a Part B only member you need to stay continuously enrolled in Medicare Part B.
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in Seniority Plus.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of Seniority Plus. We cannot make you leave Seniority Plus for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your Plan Membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the plan premiums, we will tell you in writing that you have a 90 –Day grace period during which you can pay the plan premiums before you are required to leave Seniority Plus

You have the right to make a complaint if we ask you to leave Health Net

If we ask you to leave Seniority Plus, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

Section 14 Legal Notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State of California may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like Health Net, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Health care plan fraud

If you believe something has occurred fraudulently, wastefully and/or abusively, in relation to your health coverage, please contact Health Net at **1-800-747-0877**. All calls will be kept confidential, and you may remain anonymous if you choose.

Member Non-Liability

In the event Health Net fails to reimburse a contracting medical provider's charges for covered services or in the event that we fail to pay a non-contracting medical provider for prior authorized services, you shall not be liable for any sums owed by Health Net.

If you go to a doctor, hospital, or other provider without the approval of your PCP --except in an emergency or when you need urgent care, out-of-area renal dialysis, or certain gynecological care or other self referred services as described in this Evidence of Coverage-- you will be responsible for paying any charges for these services. Neither Original Medicare nor Health Net will pay for non-emergency services or non-urgently needed care without the prior authorization of your PCP.

Circumstances Beyond Health Net's Control

Except as otherwise required by applicable law or regulation, to the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant Medical Group personnel, or other similar events, not within the control of Health Net, results in the facilities, or personnel, of

Health Net not being available to provide or arrange for services or benefits under this Evidence of Coverage, Health Net's obligation to provide such services or benefits shall be limited to the requirement that Health Net make a good faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities or personnel.

When A Third Party Causes A Member Injuries

Except as otherwise required by applicable law or regulation, if you are ever injured through the actions of another person (a third party), Health Net will provide benefits for all covered services that you receive through this plan. However, if you receive money because of your injuries, you must reimburse Health Net or the medical providers for the value of any services provided to you through this Plan.

Examples of how an injury could be caused by the actions of another person:

- You are in a car accident and the other driver is at fault.
- You slip and fall in a store because a wet spot was left on the floor.

Steps You Must Take

Health Net's legal right to reimbursement is called a lien.

If you are injured because of a third party, you must cooperate with Health Net's and the medical providers' efforts to obtain reimbursement, including:

- Telling Health Net and the medical providers the name and address of the third party, if you know it, the name and address of your lawyer, if you are using a lawyer, and describing how the injuries were caused.
- Completing any paperwork that Health Net or the medical providers may require to assist in enforcing the lien.
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions.
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the third parties or their insurance companies.
- Holding any money that you or your lawyer receive from the third party or their insurance companies in trust, and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid by the third party.

How The Amount Of your Reimbursement Is Determined
Your reimbursement to Health Net or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the provider was paid and will be determined as

permitted by law. Unless the money that you receive came from a Workers' Compensation claim, the following applies:

- The amount of the reimbursement that you owe Health Net or the physician group will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.
- The amount of the reimbursement that you owe Health Net or the physician group will also be reduced by a pro rata share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net or the physician group for services you receive under this plan will not exceed one-third of the money that you receive if you do engage a lawyer, or one-half of the money you receive if you do not engage a lawyer.
- Coordination of benefits protects you from higher plan premiums. The end result is more affordable health care.

Organ Donation

In the event that a person or a person's family is in the position to make a decision regarding organ donation, it should be taken into consideration that advancements allow many patients to benefit from organ transplants, but the supply of organs has not kept pace with the number of eligible patients. The benefits of organ donation to patients awaiting a transplant include the chance to lead a happier, more productive life.

A person can elect to be an organ donor by various methods that include provisions within Section 12811 (b) and 13005(b) of the California Vehicle Code, and Section 7150.5 of the California Health and Safety Code.

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Health Net of California (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How we may use and disclose your protected health information

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- **Payment.** We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment or premium billing.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment**. We may use and disclose your protected health information to assist your health care providers (doctors, hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, which is usually the employer.

  If the plan sponsor provides plan administration services, we may also provide access to health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

  We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who's involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

Other permitted or required disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.

- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other uses or disclosures with an authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your rights regarding your protected health information

You have certain rights regarding protected health information that the Plan maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

- **Right To Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

  If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. ***We may not agree to your request.*** If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right To Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

Health information security

Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes to this notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.healthnet.com. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the privacy office listed at the end of this Notice.

We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

Contact the plan

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

Address: **Health Net Privacy Office**
Attention: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: **1-800-522-0088**
Fax: **1-818-676-8981**
Email: Privacy@healthnet.com

Section 15 Mental Health Care and Chemical Dependency Benefits

The Mental Health and Chemical Dependency benefits are administered by Managed Health Network (MHN). MHN is licensed in the State of California as a specialized health care service plan and contracts with Health Net to underwrite and administer these benefits.

To be covered, MHN must authorize these services and supplies.

MHN will refer you to a nearby Contracted Mental Health Professional. That professional will evaluate you to determine if additional treatment is necessary. If you need treatment, the Contracted Mental Health Professional will develop a Treatment Plan and submit that plan to MHN for review. When authorized by MHN, the proposed services will be covered by this Plan.

If MHN does not approve the Treatment Plan, no further services or supplies will be covered for that condition. However, MHN may direct you to community resources where alternative forms of assistance are available.

Transition of Care For New Enrollees

If you are receiving ongoing care for an Acute, serious, or chronic mental health condition from a non-Contracted Mental Health Professional at the time you enroll with Health Net, we may temporarily cover services from a provider not affiliated with MHN, subject to applicable copayments and any other exclusions and limitations of this Plan.

Your non-Contracted Mental Health Professional must be willing to accept MHNs standard mental health provider contract terms and conditions, including, but not limited to rates, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, and be located in the Plan's Service Area.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please call the Member Services Department at the telephone number on your Health Net Seniority Plus ID Card or on the front of this booklet.

The following benefits are provided:

The following services are covered under Health Net Seniority Plus. Please refer to Section 4 of the Health Net Seniority Plus Evidence of Coverage for copayment and coinsurance information.

Outpatient Services

Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to Chemical Dependency may be covered with unlimited

visits, subject to Medical Necessity review as determined by MHN. Medication management care is also covered when appropriate. Refer to the "Outpatient mental health care" and "Outpatient substance abuse services" portions of Section 4 in the Evidence of Coverage for member cost shares.

Second Opinion

MHN may, as a condition of coverage, require that a Member obtain a second opinion from an appropriate Contracted Mental Health Professional to verify the Medical Necessity or appropriateness of a Covered Service. In addition, you as a Member, have the right to request a second opinion when:

- Your Contracted Mental Health Professional renders a diagnosis or recommends a Treatment Plan that you are not satisfied with;
- You are not satisfied with the result of the treatment rendered;
- You question the reasonableness or necessity of recommended surgical procedures;
- You are diagnosed with, or a Treatment Plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including but not limited to a Serious Chronic Condition; or
- Your Contracted Mental Health Professional is unable to diagnose your condition or test results are conflicting.
- The clinical indications are complex or confusing, a diagnosis is in doubt due to conflicting test results, or the Contracted Mental Health Professional is unable to diagnose the condition.
- The Treatment Plan in progress is not improving your medical condition within an appropriate period of time for the diagnosis and plan of care.
- If you have attempted to follow the plan of care or consulted with the initial Contracted Mental Health Professional due to serious concerns about the diagnosis or plan of care.

To request an authorization for a second opinion contact MHN. MHN will review the request, and if a second opinion is considered Medically Necessary, MHN will authorize a referral to a Contracted Mental Health Professional. When you request a second opinion, you will be responsible for any applicable copayments.

Second opinions will only be authorized for Contracted Mental Health Professionals, unless it is demonstrated that an appropriately qualified Contracted Mental Health Professional is not available. MHN will ensure that the provider selected for the second opinion is appropriately licensed and has expertise in the specific clinical area in question.

If the Member faces an imminent and serious threat to health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness would be detrimental to the ability to regain maximum function, the second opinion will be rendered in a timely fashion appropriate to the nature of the condition not to exceed 72 hours of MHNs receipt

of the request, whenever possible. For a complete copy of this policy, contact MHN at **1-800-646-5610** (TDD/TTY **1-800-327-0801**).

Any service recommended must be authorized by MHN in order to be covered.

Inpatient Services

If you think you require Inpatient services, you must obtain preauthorization from MHN. You must provide all necessary information concerning your problem before you begin treatment.

Inpatient treatment of a Mental Disorder or Chemical Dependency is covered, subject to a combined lifetime maximum of 190 days per Member. The 190-day limit does not apply to Mental Health or Chemical Dependency services provided in a psychiatric unit of a general hospital. Refer to the "Inpatient mental health care" portion of Section 4 in the Evidence of Coverage for member cost shares.

Covered services and supplies include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is determined to be Medically Necessary.
- Supplies and ancillary services normally provided by the facility, including professional services, laboratory services, drugs and medications dispensed for use during the confinement, psychological testing and individual, family or group therapy or counseling.

Except in an emergency, services and supplies provided without preauthorization will not be covered by MHN – even if those services or supplies would have been covered had the Member requested preauthorization.

Detoxification

Inpatient services for Acute detoxification and treatment of Acute medical conditions relating to Chemical Dependency are covered, except as stated in the "Mental Disorders and Chemical Dependency" portion of "Exclusion and Limitations."

Serious Emotional Disturbances of a Child (SED)

This plan may cover the diagnosis and treatment of Medically Necessary services for Serious Emotional Disturbances of a Child to the same extent that medical or surgical conditions are covered by your medical plan.

This means that, for services rendered by MHN Participating Providers only, your copayments, deductibles and annual and lifetime maximums applicable to certain mental health conditions will not be less favorable to you than coverage under your medical plan for physical conditions. Please refer to the Definitions section of this Evidence of Coverage for details on applicable conditions and levels of coverage.

Severe Mental Illness

This Plan may cover the diagnosis and treatment of Medically Necessary services for Severe Mental Illness of a person of any age. Please refer to the Definitions section of this Evidence of Coverage for details on applicable conditions and levels of coverage.

Mental Disorders and Chemical Dependency Exclusions and Limitations

Mental health care as a condition of parole, probation or court-ordered testing for Mental Disorders is limited to Medically Necessary services and subject to this Plan's visit limits described earlier in this section.

Services and supplies for treating Mental Disorders and Chemical Dependency are covered only as specified in Section 4 of the Evidence of Coverage under "Inpatient mental health care," "Outpatient mental health care" and "Outpatient substance abuse services." The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is also covered.

The following items and services are limited or excluded under the Mental Disorders and Chemical Dependency Services:

- Court-ordered testing and treatment, except when Medically Necessary and within the allowable visits under the plan contract.
- Private Hospital rooms and/or private duty nursing, unless determined to be a Medically Necessary Service and Authorization from MHN is obtained.
- Ancillary services such as:
    a. Vocational rehabilitation and other rehabilitation services.
    b. Behavioral training.
    c. Speech or occupational therapy.
    d. Sleep therapy and employment counseling.
    e. Training or educational therapy or services.
    f. Other education services.
    g. Nutrition services
- Treatment by providers other than those within licensing categories then recognized by MHN as providing Medically Necessary Services in accordance with applicable medical community standards.
- Services in excess of those with respect to which Authorization by MHN is obtained.
- Psychological testing except as conducted by a licensed psychologist for assistance in Treatment Planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological

testing related to medical conditions or to determine surgical readiness and automated computer based reports.

- All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a practitioner in connection with Inpatient treatment.
- Inpatient services, treatment, or supplies rendered without Authorization, except in the event of Emergency Care Services.
- Healthcare services, treatment, or supplies rendered in a non-emergency by a provider who is not a Contracted Mental Health Professional, unless Authorization by MHN has been received or as otherwise provided by the Plan.
- Damage to a hospital or facility caused by the Member.
- Healthcare services, treatment or supplies determined to be Experimental by MHN in accordance with accepted mental health standards, except as otherwise required by law.
- Treatment for biofeedback, acupuncture or hypnotherapy.
- Healthcare services, treatment, or supplies rendered to the Member which are not Medically Necessary Services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, Custodial Care or Domiciliary Care as determined by MHN.
- Services received before the Member's effective date, during an Inpatient stay that began before the Member's effective date or services received after the Member's coverage ended, except as specifically stated herein.
- Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.
- Services performed in any emergency room which are not directly related to the treatment of a Mental Disorder.
- Services received out of the Member's primary state of residence except in the event of Emergency Services and Care and as otherwise authorized by MHN.
- Electro-Convulsive Therapy (ECT) except as authorized by MHN according to MHN policies and procedures.
- All other services, confinements, treatments or supplies not provided primarily for the treatment of specific covered benefits and/or specifically included as Covered Services elsewhere in this Plan.

How to file a claim for Mental Health and Chemical Dependency Services

In most cases your mental health provider will submit your claims to MHN. To file a claim you may have, please send us a letter or complete an MHN Claim Form. If you need a claim form, go

online to www.mhn.com or contact MHN at **1-800-646-5610** (TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week.

Attach your itemized bill to the claim form or letter. Mail the itemized bill, completed claim form or letter to:

MHN Claims Department
Post Office Box 14621
Lexington, KY 40512-4621

We will mail you notification of our determination on your claim within 72 hours of receipt of your claim. If a reimbursement is due to you, a check will be mailed within 30 days of receipt of your claim.

When a Member Receives Emergency/Urgent Services From a Non-Contracting MHN Provider/Facility

A member may be hospitalized at a non-MHN facility due to an immediate medical emergency. The Member may be transferred to an MHN facility as soon as the member's medical condition is stable enough for such a move. If MHN arranges a transfer, MHN will be financially responsible for the cost of the transportation to an MHN facility. When receiving Emergency Care from a non-MHN provider, the member should request that the provider bill MHN directly for services. If the provider bills you directly, MHN will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. In order to receive reimbursement, the member should submit an itemized bill and completed claim form to MHN. A claim form can be obtained online at www.mhn.com or by contacting MHN at **1-800-646-5610** (or **1-800-327-0801** TDD/TTY for the hearing and speech impaired) 24 hours a day, seven days a week. Completed claim forms should be submitted to:

MHN Claims Department
Post Office Box 14621
Lexington, KY 40512-4621

QUESTIONS?

For up-to-date provider information or to obtain authorization to receive services, please contact MHN at **1-800-646-5610** (or **1-800-327-0801** TDD/TTY for the hearing and speech impaired) 24 hours a day, seven days a week. Or visit MHNs web site at www.mhn.com for a list of MHN Contracted Mental Health Professionals in your area.

Section 16 Optional Supplemental Benefits

This Section contains details on Health Net Seniority Plus Benefits that are provided by Health Net Dental, Health Net Vision Program and American Specialty Health Plans of California, Inc (ASH).

This Evidence of Coverage, any amendments we may send you, and your enrollment form, is our contract with you. It explains your rights, benefits, and responsibilities as a member of Health Net Seniority Plus. It also explains our responsibilities to you. The information in this Section is in effect for the time period from January 1, 2007, through December 31,2007.

Health Net Member Services:

For help or information, please call Member Services, 8:00 a.m. to 8:00 p.m., 7 days a week. Calls to these numbers are free:

1-800-275-4737
TTY: 1-800-929-9955

Chiropractic Services

NOTE: ***All Health Net Seniority Plus members have Medicare covered Chiropractic benefits (manual manipulation to correct subluxation). Only Health Net members who have purchased the Optional Supplemental Benefit Package 1 or 2 have non-Medicare covered routine chiropractic benefits. Please see Section 4 under "Extra benefits you can buy (these are called "optional supplemental benefits")" for copayment and benefit information.***

American Specialty Health Plans of California, Inc. (ASH Plans) will arrange covered Chiropractic Services for you. You may access any ASH Contracted Chiropractor without a physician referral, including without a referral from your PCP. All covered Chiropractic Services require prior authorization by ASH Plans, except as listed below. The ASH Contracted Chiropractor you select will provide the initial examination and will contact ASH Plans for authorization of the treatment plan he/she develops for you. For a list of ASH Contracted Chiropractors, please call ASH Plans at **1-800-678-9133** (TDD/TTY **877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays.

You may receive covered Chiropractic Services from any ASH Contracted Chiropractor at any time, and you are not required to pre-designate the ASH Contracted Chiropractor from whom you will receive covered Chiropractic Services. You must receive covered Chiropractic Services from a ASH Contracted Chiropractor, except that:

- You may receive Emergency Chiropractic Services from any chiropractor, including a non-ASH Contracted Chiropractor; and
- If covered Chiropractic Services are not available and accessible, you may obtain covered Chiropractic Services from a non-ASH Contracted Chiropractor who is available and accessible to you upon referral by ASH Plans.

All covered Chiropractic Services require prior authorization by ASH Plans except:

- An initial examination by a ASH Contracted Chiropractor and the provision or commencement, in the initial examination, of Medically Necessary services that are covered Chiropractic Services, to the extent consistent with professionally recognized standards of practice; and
- Emergency Chiropractic Services.

When ASH Plans approves a treatment plan, the approved services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination, in each subsequent office visit, if deemed necessary by the ASH Contracted Chiropractor, without additional approval by ASH Plans.

What Chiropractic Services are covered?

Office Visits

- An initial examination is performed by a ASH Contracted Chiropractor to determine the nature of your problem, to provide or commence, in the initial examination, Medically Necessary Chiropractic Services that are covered services, to the extent consistent with

professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to you if you seek services from a ASH Contracted Chiropractor for any injury, illness, disease, functional disorder, or condition with regard to which you are not, at that time, receiving services from the ASH Contracted Chiropractor. A copayment will be required.

- Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve an adjustment, a brief re-examination, and other services, in various combinations. A copayment will be required for each visit to the office.
- Adjunctive therapies, as set forth in a treatment plan approved by ASH Plans, may involve therapies such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.
- A re-examination may be performed by the ASH Contracted Chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.

Second Opinion

If *you would like* a second opinion with regard to covered services provided by a ASH Contracted Chiropractor, you will have direct access to any other Seniority Plus Contracted Chiropractor. Your visit to a ASH Contracted Chiropractor for purposes of obtaining a second opinion generally will count as one visit, for purposes of any maximum benefit, and you must pay any copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Contracted Chiropractor.

However, if the first ASH Contracted Chiropractor *refers you* to a second ASH Contracted Chiropractor to obtain a second opinion, this visit will not count as a visit, for purposes of any maximum benefit. The visit to the first ASH Contracted Chiropractor will count toward any maximum benefit.

X-ray and Laboratory Tests

X-rays and laboratory tests are payable in full when prescribed by a ASH Contracted Chiropractor and authorized by ASH Plans. Radiological consultations are a covered benefit when covered by ASH Plans as Medically Necessary Chiropractic Services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital which has contracted with ASH Plans to provide those services. ASH Plans approval of x-rays, laboratory tests, and radiological consultations is not required to the extent any such services constitute Emergency Chiropractic Services. X-ray second opinions are covered only when performed by a radiologist to verify suspected tumors or fractures.

Chiropractic Services Exclusions and Limitations

The following items and services are limited or excluded under Chiropractic Services:

- Chiropractic Services are covered up to a maximum number of 30 visits (combined with Acupuncture Services) per Calendar Year for each Member.
- Outpatient Prescription Drugs or over-the-counter drugs are not covered as part of your Chiropractic benefits. Please refer to your Evidence of Coverage for more information about outpatient prescription drugs under your medical or prescription drug (Part D) benefits.
- Durable Medical Equipment is not covered.
- Educational programs, non-medical self-care, self-help training or any self-help physical exercise training or related diagnostic testing are not covered.
- Hypnotherapy, behavior training, sleep therapy and weight programs are not covered.
- Services provided by chiropractors who do not contract with ASH Plans are not covered, except with regard to Emergency Chiropractic Services or upon a referral by ASH Plans.
- Examinations or treatments for conditions unrelated to Neuromusculo-skeletal Disorders are not covered. This means physical therapy not associated with spinal, muscle and joint manipulation, is not covered.
- Services provided by a chiropractor practicing outside California are not covered, except with regard to Emergency Chiropractic Services.
- Services that are not within the scope of licensure for a licensed chiropractor in California, as defined by the Knox Keene Health Care Service Plan Act of 1975.
- The diagnostic measuring and recording of body heat variations (thermography) are not covered.
- Transportation costs are not covered, including local ambulance charges.
- Services or treatments that are not documented as Medically Necessary chiropractic care are not covered.
- Vitamins, minerals, nutritional supplements or other similar products are not covered.

How to File a claim for Chiropractic services

In most cases your Chiropractic service provider will submit your claims to ASH Plans. To file a claim you may have, please send us a letter or complete an ASH claim form. If you need a claim form, go online to www.ashcompanies.com or contact ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays.

Attach your itemized bill to the claim form or letter. Mail the itemized bill, completed claim form or letter to:

ASH Plans
P.O. Box 509002

San Diego, CA 92150-9002

We will mail you notification of our determination on your claim within 72 hours of receipt of your claim. If a reimbursement is due to you, a check will be mailed within 30 days of receipt of your claim.

When a Member Receives Emergency/Urgent Services From a Non-Contracting ASH Plan Provider/Facility

When receiving Emergency Care from a non-ASH Plan Provider, the member should request that the provider bill ASH Plan directly for services. If the provider bills you directly, ASH Plan will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. In order to receive reimbursement, the member should submit an itemized bill and completed claim form to ASH Plan. A claim form can be obtained online at www.ashcompanies.com or by contacting ASH Plan at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays. Completed claim forms should be submitted to:

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

QUESTIONS?

For up-to-date provider information or to obtain authorization to receive services, please contact ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays. Or visit ASH Plan's web site at www.ashcompanies.com for a list of ASH Plan participating providers in your area.

Acupuncture Services

NOTE: ***Only Health Net members who have purchased the Optional Supplemental Benefit Package 1 or 2 have non-Medicare covered routine Acupuncture benefits. Please see Section 4 under "Extra benefits you can buy (these are called "optional supplemental benefits")" for copayment and benefit information.***

American Specialty Health Plan of California, Inc. (ASH Plans) will arrange covered Acupuncture Services for you. You may access any ASH Contracted Acupuncturist without a Physician referral, including without a referral from your PCP. All covered Acupuncture Services require prior authorization by ASH Plans, except as listed below. The ASH Contracted Acupuncturist you select will conduct the initial examination and will contact ASH Plans for authorization of the treatment plan he/she develops for you.

You may receive covered Acupuncture Services from any ASH Contracted Acupuncturist at any time, and you are not required to pre-designate, at any time, the ASH Contracted Acupuncturist from whom you will receive covered Acupuncture Services. You must receive covered Acupuncture Services from a ASH Contracted Acupuncturist except that:

- You may receive Emergency Acupuncture Services from any acupuncturist, including a non-ASH Contracted Acupuncturist; and
- If covered Acupuncture Services are not available and accessible, you may obtain covered Acupuncture Services from a non-ASH Contracted Acupuncturist who is available and accessible to you upon referral by ASH Plans.

All covered Acupuncture Services require prior authorization by ASH Plans except:

- An initial examination by a ASH Contracted Acupuncturist and the provision or commencement, in the initial examination, of Medically Necessary services that are covered Acupuncture Services, to the extent consistent with professionally recognized standards of practice; and
- Emergency Acupuncture Services.

When ASH Plans approves a treatment plan, the approved services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the ASH Contracted Acupuncturist, without additional approval by ASH Plans.

What Acupuncture Services are covered?

Office Visits

- An initial examination is performed by a ASH Contracted Acupuncturist to determine the nature of your problem, to provide or commence, in the initial examination, Medically/Clinically Necessary Acupuncture Services that are covered services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to you if you seek services from a ASH Contracted Acupuncturist for any injury, illness, disease, functional

disorder or condition with regard to which you are not, at that time, receiving services from the ASH Contracted Acupuncturist. A $10 copayment will be required.

- Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve acupuncture treatment, a brief re-examination and other services, in various combinations. A copayment will be required for each visit to the office.
- Adjunctive therapies, as set forth in a treatment plan approved by ASH Plans, may involve therapies such as acupressure, breathing techniques; exercise, nutrition and oriental massage may be provided in an office visit.
- A re-examination may be performed by the ASH Contracted Acupuncturist to assess the need to continue, extend or change a treatment plan approved by ASH Plans. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.
- Subsequent visits are covered as approved by ASH Plans.
- The treatment of Pain, Nausea or Neuromusculo-skeletal Disorders are covered, provided that the condition may be appropriately treated by a ASH Contracted Acupuncturist in accordance with professionally recognized standards of practice. Covered Pain conditions include low back Pain, post-operative Pain and post-operative dental Pain. Nausea includes adult post-operative Nausea and vomiting, chemotherapy Nausea and vomiting and Nausea of pregnancy. Neuromusculo-skeletal Disorders include musculoskeletal conditions such as fibromyalgia and myofascial Pain. Other conditions for which Covered Services also are available, if Medically Necessary, include carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation and tennis elbow.
- Acupuncture Services that are non-Investigational, proven and meet professionally recognized standards of practice in the acupuncture provider community are covered. ASH Plans will determine what will be considered Experimental or Investigational.
- Only Acupuncture Services or treatments that are Medically Necessary are covered.

Second Opinion

If *you would like* a second opinion with regard to covered services provided by a ASH Contracted Acupuncturist, you will have direct access to any other ASH Contracted Acupuncturist. Your visit to a ASH Contracted Acupuncturist for purposes of obtaining a second opinion generally will count as one visit, for purposes of any maximum benefit, and you must pay any copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Contracted Acupuncturist.

However, if the first ASH Contracted Acupuncturist *refers you* to a second ASH Contracted Acupuncturist to obtain a second opinion, this visit will not count as a visit, for purposes of any maximum benefit. The visit to the first ASH Contracted Acupuncturist will count toward any maximum benefit.

Acupuncture Services Exclusions and Limitations

The following items and services are limited or excluded under the Acupuncture Services:

- Acupuncture Services are covered up to the maximum number of 30 visits (combined with Chiropractic Services) per Calendar Year.
- All auxiliary aids and services, including but not limited to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
- Lab tests, X-rays and other treatments not documented as Medically/Clinically Necessary as appropriate or classified as Experimental or Investigational and/or as being in the research stage, as determined in accordance with professionally recognized standards of practice.
- Outpatient Prescription Drugs and over-the-counter drugs are not covered as part of your Acupuncture benefits. Please refer to your Evidence of Coverage for more information about outpatient prescription drugs under your medical or prescription drug (Part D) benefits.
- Durable Medical Equipment is not covered.
- Educational programs, non-medical self-care, self-help training or any self-help physical exercise training or any related diagnostic testing are not covered.
- Charges for Hospital confinement and related services are not covered.
- Charges for anesthesia are not covered.
- Hypnotherapy, sleep therapy, behavior training and weight programs are not covered.
- Services provided by acupuncturists who do not contract with ASH Plans are not covered, except with regard to Emergency Acupuncture Services or upon referral by ASH Plans.
- Only Acupuncture Services that are listed under "What Acupuncture Services are covered." Unlisted services, which include, without limitation, services to treat asthma and services to treat any addiction, including treatment for smoking cessation, are not covered.
- Services provided by an acupuncturist practicing outside California are not covered, except with regard to Emergency Acupuncture Services:
    a) No prior authorization is required for Emergency Acupuncture Services
    b) ASH Plans determinations to deny coverage for Emergency Acupuncture Services may be appealed to Health Net
- The diagnostic measuring and recording of body heat variations (thermography) are not covered.
- Only services that are within the scope of licensure of a licensed acupuncturist in California are covered, as defined by the Knox Keene Health Care Service Plan Act of 1975.
- Other services, including, without limitation, ear coning and Tui Na are not covered. Ear coning, also sometimes called "ear candling," involves the insertion of one end of a long, flammable cone (the "ear cone") into the ear canal. The other end is ignited and allowed to

burn for several minutes. The ear cone is designed to cause smoke from the burning cone to enter the ear canal to cause the removal of earwax and other materials. Tui Na, also sometimes called "Oriental Bodywork" or "Chinese Bodywork Therapy," utilizes the traditional Chinese medical theory of Qi but is taught as a separate but equal field of study in the major traditional Chinese medical colleges and does not constitute acupuncture.

How to File a claim for Acupuncture services?

In most cases your Acupuncture service provider will submit your claims to ASH Plans. To file a claim you may have, please send us a letter or complete an ASH Plans claim form. If you need a claim form, go online to www.ashcompanies.com or contact ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays.

Attach your itemized bill to the claim form or letter. Mail the itemized bill, completed claim form or letter to:

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

We will mail you notification of our determination on your claim within 72 hours of receipt of your claim. If a reimbursement is due to you, a check will be mailed within 30 days of receipt of your claim.

When a Member Receives Emergency/Urgent Services From a Non-Contracting ASH Plan Provider/Facility

When receiving Emergency Care from a non-ASH Plan Provider, the member should request that the provider bill ASH Plan directly for services. If the provider bills you directly, ASH Plan will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. In order to receive reimbursement, the member should submit an itemized bill and completed claim form to ASH Plan. A claim form can be obtained online at www.ashcompanies.com or by contacting ASH plan at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays.

Completed claim forms should be submitted to:

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

QUESTIONS?

For up-to-date provider information or to obtain authorization to receive services, please contact ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays. Or visit ASH Plan's web site at www.ashcompanies.com for a list of ASH Plan participating providers in your area.

Vision Care

NOTE: ***All Health Net Seniority Plus members have Medicare covered Vision benefits. Only Health Net members who have purchased the Optional Supplemental Benefit Package 1 or 2 have non-Medicare covered routine Vision benefits. Please see Section 4 under "Extra benefits you can buy (these are called "optional supplemental benefits")" for copayment and benefit information.***

Using your coverage for Vision Care

Eyewear

You can obtain an annual eye exam with your basic medical benefit through your Health Net Seniority Plus contracting medical group. In addition to an annual routine eye exam and Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye), we also offer coverage for your eyewear. Please refer to the "Vision Care" portion of the Benefit Chart in Section 4 of your Evidence of Coverage for Medicare-covered and non Medicare-covered member cost shares for eyewear. The Health Net Vision Plan is serviced by EyeMed Vision Care, LLC. Eyemed will pay your provider its share of the bill for any covered services that are determined to have been Medically Necessary and let you know what, if anything, you must pay your provider.

How to use the plan

- Make arrangements for your routine annual eye exam through your contracting Medical Group or Primary Care Physician (PCP). For referral to a specialist (ophthalmologist or optometrist), please contact your PCP directly. Vision care provided by someone other than a Health Net Medical Seniority Plus contracted optometrist or ophthalmologist will not be covered.

- Go to your eye exam and if you require eyeglasses or contact lenses, a prescription will be written. You are able to purchase eyewear from a list of Health Net Vision participating eyewear providers in California. Please note that the specialist who is authorized to provide your eye exam may not be a Health Net Vision contracting provider. Eyewear supplied by providers other than Health Net Vision Participating Eyewear providers are not covered. For more information or a list of Health Net Vision participating eyewear providers in California, please contact Health Net Vision at 1-866-392-6058 Monday through Saturday, 5:00 a.m. – 8:00 p.m. and Sunday 8:00 a.m. – 5:00 p.m. Pacific time (or 1-866-308-5375 TDD/TTY for the hearing and speech impaired Monday through Friday from 5:00 a.m. to 2:00 p.m. Pacific time) or visit our website at www.healthnet.com.

- Payment for the prescription order eyewear received from a Health Net Vision participating eyewear provider will be made directly to that Health Net Vision participating provider.

That's all you need to do to get your new eyeglasses or contact lenses. The Health Net Vision participating provider will take care of all of the paperwork and billing for you.

If you have questions about your Vision Care benefits or would like a list of Health Net Vision participating Eyewear providers, you may call the Health Net Vision Customer Service Department at **1-866-392-6058**. Normal business hours are Monday-Saturday, 5:00 a.m. to 8:00 p.m. and Sunday,

8:00 a.m. to 5:00 p.m. TDD/TTY services are available Monday-Friday during the hours of 5:30 a.m. to 2:00 p.m. at **1-866-308-5375**.

Eyewear Benefits

Eyewear benefits differ from all others in that no copayment is specified. However, you must pay the difference between the retail price of Eyewear and the Eyewear allowance described below. When the cost sharing column states "Health Net Vision pays in full," you owe nothing.

Eyewear Schedule:

Cost Sharing:

Frames

(one pair of Frames during a 24-month period)* .....Health Net Vision pays the first $100, then the Member pays 80% of the remaining balance, if applicable.

Standard Plastic Eyeglass Lenses (one pair every 24 months *):

Single vision.....Health Net Vision pays in full

Bifocal.....Health Net Vision pays in full

Trifocal.....Health Net Vision pays in full

Progressive Lenses..... Health Net Vision pays $82.50, member pays the remaining balance.

Eyeglass Lens Options(one pair every 24 months*):

Tint Pink or Rose #1 or #2 (only).....Health Net Vision pays in full

**Multi year benefits may no be available in subsequent years.*

Contact Lenses - in lieu of eyeglass lenses
(includes fit, follow-up and materials):

Conventional / Cosmetic (one pair every 24 months*) ..... Health Net Vision pays the first $100, then the Member pays 85% of the remaining balance, if applicable.

Disposable / Cosmetic
(If disposable Contact Lenses are used, you need to purchase enough pairs of disposable contact lenses to reach the allowable amount shown in "Eyewear Schedule" at one visit. If you do not use the full $100 allowed amount during the initial purchase, the remaining balance will not carry over) ..... Health Net Vision pays the first $100, Member pays the remaining balance.

Medically necessary ** (one pair every 24 months*)
Conventional or Disposable ..... Health Net Vision pays the firs $250, Member pays the remaining balance.

**Multi year benefits may no be available in subsequent years.*

*** Contact lenses are defined as Medically Necessary if the individual is diagnosed with one of the following conditions:*

- *Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.*
- *High Ametropia exceeding -12 D or +9 D in spherical equivalent.*
- *Anisometropia of 3 D or more.*
- *Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.*

If the Member is diagnosed with a Medically Necessary condition, the Health Net Vision provider will submit a request for pre-authorization to Health Net Vision. The Health Net Vision Medical Director reviews all requests for Medically Necessary contact lenses. If approved, the individual will be covered for Medically Necessary contact lenses up to the plan allowance.

An additional pair of Eyeglass Lenses or Contact Lenses (whether cosmetic or Medically Necessary) may be covered. If, after 12 consecutive months from the date the Lenses are dispensed, one of the following occurs:

- There is a change in diopter of at least 0.50 in one eye, or if the change occurs in both eyes, the total for both is 0.50.
- There is a shift in axis of astigmatism of greater than 15 degrees.
- There is a change in vertical prism greater than 1 prism diopter.
- The Physician or Optometrist prescribes either a change in Lens type, or a change from Eyeglasses to Contact Lenses or from Contact Lenses to Eyeglasses.

Applicable cost sharing amounts and benefits maximums will apply.

Vision Care Exclusions and Limitations

The following items and services are limited or excluded under Health Net Vision Care:

- Eye exams are not covered under the Vision Care benefit. Routine eve exams are covered as part of your plan's medical benefit. Please refer to the Health Net Seniority Plus Evidence of Coverage, Section 4, titled "Benefits Chart – a list of services you get as a Member of Seniority Plus."
- The fitting or dispensing of more than one set of Frames and one pair of Standard Plastic Eyeglass Lenses or Contact Lenses during any 24-month period is not covered, except in cases where the member's prescription changes significantly (refer to the Eyewear Schedule for more information). Please note that Health Net of California, Inc. contracts with Medicare each year and that this benefit may/may not be available next year.
- Lenses that correct the vision defect known as aniseikonia are not covered.
- Diagnostic services, and medical or surgical treatment of the eye are not covered. For covered surgical treatments please refer to the Health Net Seniority Plus Evidence of Coverage, Section 4, titled "Benefits Chart – a list of services you get as a Member of Seniority Plus."
- Services or supplies provided by a provider other than a Health Net Vision Participating Eyewear provider are not covered.
- Nonprescription vision devices and sunglasses are not covered.
- Additional fitting and measurement charges, or special consultation charges due to the purchase of optional Frames, are not covered.
- Orthoptics or vision training aids are not covered.
- Outpatient Prescription Drugs or over-the-counter drugs are not covered as part of your Vision Care benefits. Please refer to your Evidence of Coverage for more information about outpatient prescription drugs under your medical or prescription drug (Part D) benefits.
- Vision aids (other than Eyeglasses or Contact Lenses) are not covered.
- The Eyewear benefit for Progressive Lenses is $82.50. Any difference between this amount and the retail price is your responsibility.
- The cost of tinting Lenses is limited to pink or rose #1 and #2 tints.
- Cost Sharing amounts are a one-time use benefit; any remaining balances will not be paid by Health Net.
- Unless an emergent or urgent care is required, out-of-network vision care services not covered.
- Lost or broken materials are not covered.

LIABILITY FOR PAYMENT

You will be responsible for the cost of any vision services received from a Health Net Vision nonparticipating provider, as well as any charges for services received from Health Net Vision participating providers that exceed the benefits listed in your Evidence of Coverage.

QUESTIONS?

For up-to-date provider information, to obtain authorization to receive services, or if you have any questions concerning claims about vision care services, please contact Health Net Vision at **1-866-392-6058** Monday through Saturday, 5:00 a.m. – 8:00 p.m. and Sunday 8:00 a.m. – 5:00 p.m. Pacific time (or **1-866-308-5375** TDD/TTY for the hearing and speech impaired Monday through Friday from 5:00 a.m. to 2:00 p.m. Pacific time). Or visit the Health Net Vision web site at www.healthnet.com for a list of Health Net Vision participating providers in your area.

Health and Fitness – Silver&Fit™

NOTE: ***This benefit is available to Health Net Seniority Plus members who have purchased the Optional Supplemental Benefit Package 1or 2.***

Silver&Fit™ is a fitness program at participating fitness clubs. Silver&Fit is provided through American Specialty Health Networks, Inc. and Healthyroads, Inc., subsidiaries of American Specialty Health Incorporated. There are no copays, co-insurance, or deductibles for Silver&Fit programs.

Prior to proceeding in any exercise or weight control program, it is important for you to seek the advice of a physician or other qualified health professional. Participation in the Silver&Fit program is at your own risk.

How do I enroll?

To enroll, you can go on-line at www.SilverandFit.com, call Silver&Fit at 1-877- 427-4788 or TTY/TDD phone 1-877-710-2746 (Monday – Friday, 5 a.m. – 6 p.m. During the enrollment process, you will choose a fitness club from the list of contracted clubs or the Silver &Fit @ Home (distance learning program) for members who do not have access to a Silver&Fit club or prefer to workout at home.

Once enrollment is complete, if you have selected the fitness club option you will present your Silver&Fit ID card to the fitness club and will sign a membership agreement with the fitness club. You may begin accessing services at that time. The membership agreement, that you will be required to sign at the fitness club, is for a $0 membership for the covered services available through the program, under the "standard fitness" membership described below. If you choose to access fitness club services otherwise available by the club at an additional fee, then the agreement may reflect costs associated with those non-program related services.

Explanation of covered services (i.e. what is a "standard fitness" membership)

The standard fitness club membership, with Silver&Fit, includes all of the services and amenities included with your network fitness club membership, such as:

- Cardiovascular equipment
- Free weights or resistance training equipment
- Exercise classes
- Where available, amenities such as saunas, steamrooms, pools, and whirlpools

It does not include any non-standard fitness club services that typically require an additional fee.

Explanation of covered services (i.e. what is a "the Silver& Fit @Home distance learning program")

If during enrollment you chose to participate in the Silver&Fit @Home program you will receive one or both of the following kits:

- Walking Kit (pedometer and walking program instructions)
- Exercise Kit (two exercise classes on DVD, an exercise cord, and handheld weights)

Services offered through the "service hotline"

Members may call Silver&Fit member services at (877) 427-4788 or TTY/TDD 1-877-710-2746, Monday through Friday, 5 a.m. – 6 p.m. (Pacific Time), for information on any of the following:

- Enrollment
- Program design
- Eligibility
- Provider search
- Changing clubs
- Provider nominations

Silver&Fit Web Site

As a Silver&Fit enrolled member, you have access to the Silver&Fit Web site, www.SilverandFit.com, which is designed as a valuable resource to you. You may:

- Utilize the fitness club locator and enrollment change features in the event you wish to change fitness clubs
- Access fitness literature to help you make healthier lifestyle choices
- Obtain discounts on health and other products
- Choose from over 130 tools and trackers to track your progress
- Access the Silver&Fit member newsletters

Exclusion and limitations

The following services are not offered:

- Services or supplies provided by any person, company or provider other than a Silver&Fit participating fitness club
- All education materials other than those produced for Silver&Fit by Healthyroads or American Specialty Health
- Telecommunications devices, telephone handset amplifiers, television recorders, and telephones compatible with hearing aids
- Education program services for individuals other than the member
- Prescription drugs, over-the-counter products, dietary supplements, herbal supplements, vitamins, minerals, weight control products, meal-replacement beverages or powders, prepackaged meals, or any other types of food or food product, whether or not it is recommended, prescribed, or supplied by a health care provider, fitness club, or program
- All listening devices, including, but not limited to, audiotape and CD players
- Services for members with serious medical conditions for which Silver&Fit services are not appropriate